State of Delaware

State of Delaware GHIP FY18 Budget Projections

Claim Liability and Minimum Reserve Recommendations

February 20, 2017

Willis Towers Watson

Today's discussion

- FY18 GHIP budget projection and trend sensitivity
- Recommended claims liability target
- Recommended minimum reserve
- Appendix

FY18 health care budget projections

Recommendation and trend sensitivity

- FY18 health care costs are projected to be $799.3M, based on claims data 1/1/2015 – 12/31/2016, Medical TPA RFP savings, and WTW estimated savings for the ESI contract changes
  - Roughly flat compared to FY17 budget
  - Reducing Active/Pre65 medical trend to 6% reduces the projected costs by $4.7M
  - Increasing Active/Pre65 medical trend to 7% and pharmacy trend to 12% increases the projected costs by $11.9M

Key Assumption – Trend	Aggressive	Recommendation	Conservative
Medical Trend – Active/Pre65	6%	6.5%	7%
Medical Trend – Medicare	3%	3%	3%
Pharmacy Trend	10%	10%	12%
FY18 Aggregate Costs	**$794.6M**	**$799.3M**	**$811.2M**
$ Difference vs. Recommended	**($4.7M)**	**--**	**$11.9M**
% Difference vs. Recommended	**-0.6%**	**--**	**1.5%**

See Appendix for additional pricing assumptions

Claim liability and minimum reserve discussion

Overview and terminology

- To maintain the stability and financial health of the GHIP, a minimum level of funding is required to be held at any point in time to protect against potential future exposure, including:
  - Claim liability: estimated amount needed to pay outstanding claims if the plan was to be terminated; reflects incurred but not paid ("IBNP") claim liability
  - Fund reserve: amount needed to protect against adverse claims experience, including any "shock" claims and fluctuations in claim levels for the current population
- The Fund Equity Balance refers to the cumulative funds available to pay claims in the health fund, and varies each month depending on actual revenue (premiums, rebates, etc.) less actual expenditures (claims, fees, etc.)
- Reserve Surplus (or Deficit) refers to the amount that the claim liability and fund reserve are over (or under) funded based on fund equity balance and target reserve levels

Claim liability and minimum reserve discussion

Projected fund equity balance

FY18 Projected Expenditures (includes estimated rebates, adjustments for EGWP subsidies/reinsurance, Medical TPA RFP savings, and ESI contract savings)	**$799.3M**
FY18 Projected Revenue (based on FY17 rates)	$804.0M FY2017 revenue (Dec 2016 enrollment) +4.9M Medicfill rates in force full fiscal year **$808.9M**
FY18 Projected Group Health Fund Revenue less Expenditures	**$9.6M**
Current FY17 Fund Equity Balance as of January 2017	**$70.5M**
FY17 Projected Year-End Fund Equity Balance	**$99.6M**

FY18 projected revenue does not reflect potential migration from Highmark HMO to the PPO plan, which would generate additional FY18 revenue and potentially increase the fund equity balance

Claim liability and minimum reserve discussion

FY18 GHIP claim liability

Recommended Claim Liability Target as of 12/31/2016*	**$54.3M**
FY17 Current Claim Liability Funded as of January 2017	**$54.3M**
FY18 Claim Liability Deficit	**$0** (fully funded)

- Recommended Claim Liability Target is based on estimated incurred but not paid ("IBNP") liability as of 12/31/2016
  - Medical Claim Liability (Highmark and Aetna): $46.1M
  - Pharmacy Claim Liability (ESI Commercial and EGWP): $8.2M
- IBNP liability is based on paid claims for the period 1/1/2016 – 12/31/2016 and lag factors developed by Willis Towers Watson as of 10/31/2016
  - Lag factors represent the average period of time between when a claim is incurred and then paid by the State, and were developed separately for Aetna, Highmark, and ESI based on data provided by each vendor
  - Lag factors will be reviewed and updated (if needed) annually

* Replaces $48m target claim liability; target to be reviewed and refreshed quarterly

Claim liability and minimum reserve discussion

FY18 GHIP minimum reserve recommendation

Health Care Trend Variability Analysis

FY18 Budget Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$799,256,000	
70% Confidence Interval	$787,736,000	$810,777,000
90% Confidence Interval	$780,973,000	$817,540,000
95% Confidence Interval	$777,470,000	$821,043,000
97% Confidence Interval	$775,134,000	$823,378,000

At the 97% confidence interval level, the upper bound is $24M higher than the projected budget

- Health care trend variability analysis provides statistical confidence intervals to better quantify volatility and address risk tolerance concerns
  - Confidence intervals represent the probability that the budget estimate will fall between an upper and lower bound of a health care claims distribution

The above analysis is based on GHIP data available through FY17 Q2, current enrollment as of December 2016 (including assumed migration for terminating plans), decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

Claim liability and minimum reserve discussion

FY18 GHIP reserve

FY18 Recommended Minimum Reserve*	**$24M**
FY17 Remaining Fund Balance as of January 2017	**$16.2M** $70.5M less $54.3M claim liability
FY17 Current Reserve Surplus/(Deficit)	**($7.8M)**

FY17 Projected Year-End Remaining Balance	**$45.3M** $99.6M less $54.3M claim liability
FY17 Projected Year-End Reserve Surplus/(Deficit)	**$21.3M**

- The Health Fund is currently underfunded by $7.8M based on a Minimum Reserve target of $24M but is expected to be fully funded by the end of FY17

* Replaces $79m target minimum reserve; target to be reviewed and refreshed annually

Appendix

FY18 health care budget development

Overview of budget development process

step 1

Data Request & Collection

- Groups: Active employees and pre-65 retirees (Aetna/Highmark/ESI) and post-65 Medicare retirees (Highmark/ESI)
- Headcount: Employees and dependents enrolled within the recent 12 months of experience
- Utilizing this data from vendor experience reports (claims, enrollment, rebates) and OMB's monthly health fund report (expenses), self-insured medical/Rx budget rates and employee contributions are developed

step 2

Assumption & Pricing Analysis

- Claims experience is adjusted to reflect:
  - Plan design/vendor/network changes
  - Legislative changes
- IBNR factors complete the claims experience, estimating the value of claims *incurred but not reported*
- Health care inflation factors, determined annually from marketplace and Willis Towers Watson survey data, and with approval from SEBC, project past claims into the future
- Offsets for prescription drug rebates and Medicare EGWP income reduce claims cost
- Health care administrative and legislative fees, including applicable ACA fees, are added to projected claims experience
- Blended health care rate: projected claims experience with health care administrative fees divided by headcount (*per person* cost)
- Blended health care rate allocated based on *actuarial value* of plan options

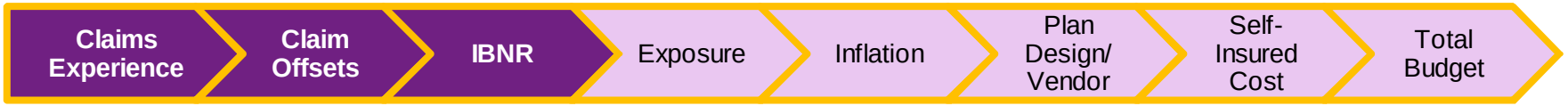
step 3

Aggregate Budget Development

- State of Delaware's July 1st fiscal year budget is based on the developed budget rates calculated in Steps 1-2, leveraging prior year claims experience and current enrollment patterns to project future cost
  - Timing requires that the claims data used to project the upcoming plan year is nearly two years old (e.g., CY16 data primarily used to set FY18 budget rates)
  - Pricing cycle typically begins in Summer/Fall when the initial Door Opener budget is developed with experience through Q3 of prior plan year
  - Budget development goes through multiple iterations with updated rolling 12-month experience; final budget will be based on data through Q2 of current fiscal year

FY18 health care budget development

Assumption and pricing analysis details



- **Claims experience** provided by vendors (Highmark, Aetna, and ESI) reflected paid claims and enrollment for the most recent available 24 months, or two experience periods, from January 2015 through December 2016
  - Period 1 (1/1/2015 – 12/31/2015) weighted 35%
  - Period 2 (1/1/2016 – 12/31/2016) weighted 65%
- Claims experience was adjusted for **claim offsets** from pharmacy rebates and EGWP funding, including:
  - Commercial Drug Rebates: Prescription drug claims are offset by actual prescription rebate payments received from ESI for the quarter payment was attributable
  - Medicare EGWP: Medicare costs offset by actual and projected[1] EGWP income; includes income from Direct Subsidy, Coverage Gap Discount, Reinsurance/LICS, and applicable Medicare drug rebates
  - Claims experience was also adjusted based on revised ESI contract terms effective 7/1/2016[2]
- **Incurred But Not Reported (IBNR)** adjustments convert paid claims to an incurred basis based on the lag between when a claim is incurred and when it is paid. Budget reflects average lag factors as of 10/31/2016

[1]Retiree Medicare plan runs on a calendar year basis, and a portion of CY2016 EGWP income is based on future projections
[2]Additional ESI contract savings projections independently verified by WTW

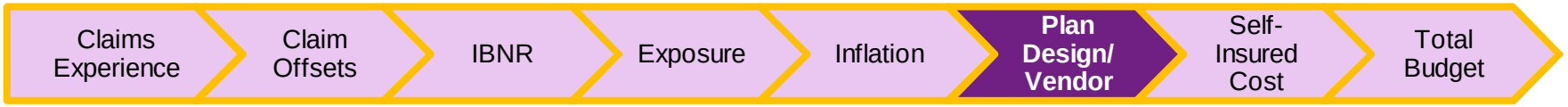
FY18 health care budget development

Assumption and pricing analysis details

- **Exposure** adjustments reflected GHIP's minor enrollment changes and converted the adjusted claims experience for each period into a *per adult* equivalent claims cost
  - Period 1 Enrollment (1/15 – 12/15): 67,500 total contracts (+2.0% from prior period)
    - Active and pre-65 retiree: 43,740
    - Medicare: 23,760
  - Period 2 Enrollment (1/16 – 12/16): 68,427 total contracts (+1.4% from prior period)
    - Active and pre-65 retiree: 43,821
    - Medicare: 24,606
- **Inflation and trend** adjustments increased the claims costs to reflect expected year-over-year increases to the cost of services; trend assumption set based on review of national survey data and GHIP-specific experience
  - The following factors were used to project GHIP claims to FY18:
    - Active and non-Medicare retiree medical trend: 6.5%
    - Medicare medical trend: 3%
    - Prescription drug trend: 10%

FY18 health care budget development

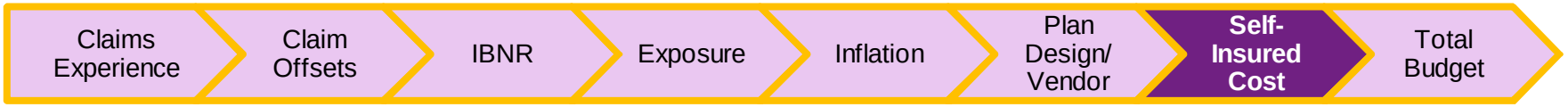
Assumption and pricing analysis details



- **Plan Design** adjustments applied to the claims costs to reflect any plan design changes or movement across plans, and were based on the relative difference in *actuarial value* of the plans
  - Period 1 claims adjusted to reflect the FY16 plan design changes to OOP limits effective 7/1/2015 and changes to Rx copays effective 9/1/2015
  - Both period claims assume no additional FY17 plan design changes effective 7/1/2016
    - No adjustment made for change in copay for urgent care centers and freestanding hi-tech imaging, pending further analysis regarding potential member steerage (data still emerging)
- **Vendor adjustments** reflect results from medical TPA RFP effective 7/1/2017
  - Aetna sole administration of the CDH Gold and HMO plans
  - Highmark retention of the Comprehensive PPO, First State Basic, POS, and Medicfill plans
  - The following migration was assumed for participants currently enrolled in discontinuing plans:
    - Highmark HMO: 75% migrate to Aetna HMO and 25% migrate to Highmark Comprehensive PPO
    - Highmark CDH Gold: 90% migrate to Aetna CDH Gold and 10% migrate to Highmark Comprehensive PPO

FY18 health care budget development

Assumption and pricing analysis details



- **Self-insured fixed costs** were added to the adjusted claims cost to develop the total budget; this includes the following administrative service fees and expenses:

Fee	Payable
Active/Pre-65 Retiree Medical ASO Fee[1]	Aetna & Highmark
Commercial Pharmacy Drug ASO Fee	ESI
Medicare Retiree Medical ASO Fee[1]	Highmark
EGWP Pharmacy Drug ASO Fee	ESI
OMB Office Expenses[2]	OMB Expenses
ACA Fees	Federal Government/HHS

[1] Medical ASO fees reflect the results of the FY18 medical TPA RFP; Aetna HMO fees reflect AIM model including Care Link fees
[2] OMB Office Expenses includes the cost of HMS-Health Advocate Inc. EAP, Truven Analytics, Ceridian/Conexis, Segal Consulting, Willis Towers Watson Consulting, Vanguard Direct (ACA reporting), OMB salaries, wages, and other employer costs

Health care cost trend overview

- Health care cost trend is made up of three main components:
  - **Unit cost**: the cost of a fixed basket of medical and Rx services
  - **Utilization**: the size of the basket of services used (i.e., whether more services are going to be used next year relative to this year)
  - **Mix:** how the assortment of services in the basket changes year over year (i.e., more urgent care visit, but fewer ER visits; more specialty drug use)

- Willis Towers Watson publishes health care cost trend information semi-annually based on data compiled for large employers; most recent 2016 Willis Towers Watson Best Practices in Health Care Survey includes results for nearly 550 large employers with 12.2 million full time employees
- Health care cost trends are reported before plan design changes and after plan design changes
  - The cost increase before plan changes (e.g., changes to deductibles, coinsurance) is a better measure of the true underlying increase in health care costs resulting from changes in utilization and unit costs, before reflecting cost shifting to employees
  - Expected 2016 to 2017 composite medical & Rx health care cost trends ***before plan changes*** are summarized below for active, pre-65 retirees, and post-65 retirees

Annual Medical/Rx Trend	Active	Pre-65 Retiree	Post-65 Retiree
Before Plan Design Changes			
National Average	6.0%	5.9%	4.7%
Public Sector & Education[1]	7.0%	n/a	n/a

[1] Industry-specific data available for active populations only

Recommended health care cost trends

- Current trend assumptions for FY18 projections (based on Segal recommendations):
  - Medical: 6.5%
  - Rx: 10.0%
  - Composite[1]: 7.6%
  - Medical and Rx trend assumptions are applied to all statuses (active, pre-65 retiree, and post-65 retirees)
- WTW Recommendation
  - Composite trend of 7.6% falls slightly above public sector/education average of 7.0%
  - WTW generally recommends setting medical trend in the 6-7% range, and pharmacy trend in the 10-12% range for active and pre-65 retiree populations
    - Segal's trend recommendations fall within these ranges
    - Consider lowering medical trend to a more aggressive 6.0% assumption
  - For the post-65 retiree population, 10-12% pharmacy trend is appropriate driven largely by continued increase in specialty drug spend, but medical trend has been running closer to 2-3%
    - Consider reducing medical trend for post-65 retirees to 3%

WTW Recommendation	Active	Pre-65 Retiree	Post-65 Retiree
Medical Trend	6.5%[2]	6.5%[2]	3.0%
Rx Trend	10.0%	10.0%	10.0%

[1] Based on a weighted average of the most recent medical & Rx claims data for FY17 Q2
[2] Consider lowering medical trend to 6.0% based on discussion with SEBC